STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005015	A. BUILDING: _____ B. WING _____	03/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANCISCAN ST ANTHONY HEALTH - MICHIGAN CIT	301 W HOMER ST MICHIGAN CITY, IN 46360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for a pre-occupancy survey of a freestanding emergency department under the main hospital's State license. Survey Date: 3/15/12 Facility Number: 005015 Surveyor: Jacqueline Brown, R.N., P.H.N.S. Franciscan St. Anthony Health - Michigan City, off-site freestanding emergency department, Chesterton Health Center, 770 Indian Boundary Rd., Chesterton, Indiana meets the requirements for Indiana State Licensure Rules 410 IAC 15-1 to admit and treat patients. QA: claughlin 03/23/12	S 000		